The Hand Center of San Francisco, Inc

Kyle D Bickel, MD **Patrick O Lang, MD**

Hand and Wrist Surgery Upper Extremity Reconstruction Microsurgery Reconstructive Surgery

2019-03-01

Chubb/Wc
Po Box 42065
Phoenix, AZ 85080

RE: Jonathan Shockley
Employer: Biotelemetry
DOI: 02/16/2019
Claim #: 7173815490

HAND SURGERY CONSULTATION

Dear Ladies and Gentlemen:

I saw this patient today for evaluation of his bilateral hand, wrist, and forearm pain. Thank you for the referral.

HISTORY OF INJURY This patient is a 40-year-old right-hand-dominant electrocardiogram technician who reports a several month history of worsening bilateral hand, wrist, and forearm pain. He reports that his job requires very intense and prolonged use of a computer and mouse. The symptoms arose in the setting of at work. He does not recall any other specific history of trauma.

CURRENT SUBJECTIVE COMPLAINTS The patient reports vague and diffuse bilateral hand, wrist, and forearm pain.

PREVIOUS WORK/INJURY HISTORY The patient reports a prior Achilles tendon injury.

PAST MEDICAL HISTORY Patient denies any significant past medical history. Surgical history includes removal of a bone spur from the foot and two prior Achilles tendon operations. Medications include aspirin and Advil as needed. He has no known drug allergies.

SOCIAL HISTORY The patient works as an electrocardiogram technician but does extensive data analysis on a computer. He previously worked as a ballet dancer. He does not smoke. He does not drink alcohol.

PHYSICAL EXAM Vital signs SPO2 100%, blood pressure 116/59, heart rate 61, respiratory 12, temperature 96.7.

Examination of the bilateral upper extremities reveals no deformity. Tinel's sign in the ulnar nerve at the elbow is negative bilaterally. Forearm compartments are soft and nontender to palpation bilaterally. Finkelstein's test is negative bilaterally. Watson's test is negative bilaterally. Wrist and digital range of motion are normal bilaterally. There is no A1 pulley tenderness or triggering throughout either hand. Sensation is grossly intact distally bilaterally.

IMPRESSION 40-year-old man with bilateral upper extremity repetitive strain injury.

TREATMENT RECOMMENDATIONS I had a lengthy discussion with the patient regarding his diagnosis of repetitive strain injury. The symptoms are undoubtedly related to his work on a computer. I recommended he begin working with an occupational hand therapist on a repetitive strain protocol. I also talked with him about optimizing his computer workstation ergonomics and using dictation software is much as possible. All questions are answered. I can see him back in 6-8 weeks to reassess his symptoms.

Thank you again for the referral. Please let me know if I can be of any further help.

Sincerely,

Patrick O Lang, M.D.
Cal Lic #A106890
POL/ja
ELECTRONICALLY SIGNED BY PATRICK O LANG, MD

Executed at San Francisco, CA. Date: 3/5/2019 6:42:42 AM
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated California Labor Code 139.3

601 Van Ness Ave Suite 2018 San Francisco CA 94102
Tel: 415.751.HAND (4263) Fax: 415.359.1925 email admin@sfhand.com
www.sfhand.com

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

X New Request ☐ Resubmission – Change in Material Facts

☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health

☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): Jonathan Shockley		
Date of Injury (MM/DD/YYYY): 02/16/2019	Date of Birth (MM/DD/YYYY): 1978-09-27	
Claim Number: 7173815490	Employer: Biotelemetry	

Requesting Physician Information

Name: Patrick O Lang, MD		
Practice Name: The Hand Center of San Francisco	Contact Name: Kim	
Address: 601 Van Ness Ave. #2018	City: San Francisco	State: CA
Zip Code: 94102	Phone: 415-751-4263	Fax Number: 415-359-1925
Specialty: Hand Surgery	NPI Number: 1194966416	
E-mail Address: admin@sfhand.com		

Claims Administrator Information

Company Name: CHUBB/WC	Contact Name: Maria Neish	
Address: PO BOX 42065	City: PHOENIX	State: AZ
Zip Code: 85080	Phone: 925-598-6030	Fax Number: 213-612-5785
E-mail Address:		

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Bilateral RSI	M79.641	Hand Therapy, Evaluation and treatment	97003, 97530, 97110, 97112	2x per week, for 6 weeks. total of 12 visits Facility: Golden Gate Hand Therapy TIN: 54-2192724 fax 415-447-3868 ph 415-359-1444

Requesting Physician Signature: Date: 3/6/19

Claims Administrator/Utilization Review Organization (URO) Response

Authorization Number (if assigned):		Date:	
Authorized Agent Name:		Signature:	
Phone:	Fax Number:	E-mail Address:	
Comments:			

CO	FILE	DEPT	CLOCK	VCHR NO	
505	271984	L27247	BT	0000080211	1

243-0001

CARDIONET LLC
1000 CEDAR HOLLOW ROAD
MALVERN PA 19355

Earnings Statement

Period Beginning: 02/03/2019
Period Ending: 02/16/2019
Pay Date: 02/22/2019

Taxable Marital Status: Single
Exemptions/Allowances:
Federal: 1
CA: 1

JONATHAN D SHOCKLEY
1000 SUTTER ST APT 123
SAN FRANCISCO CA 94109

Social Security Number: XXX-XX-7160

Earnings	rate	hours	this period	year to date
Regular	20.5000	64.40	1,320.20	5,932.70
Overtime	30.7500	.50	15.38	95.33
Shift 2 Differe	1.0000	35.60	35.60	156.80
Sick Time	20.5000	16.00	328.00	328.00
Sw1	0.5000	3.00	1.50	7.55
Sw2	1.5000	20.70	31.05	155.85
Sw2 Ot2	1.5000	1.00	1.50	9.30
Holiday				328.00
	Gross Pay		**$1,733.23**	7,262.61

Deductions	Statutory		
	Federal Income Tax	-162.71	706.08
	Social Security Tax	-107.10	448.85
	Medicare Tax	-25.04	104.97
	CA State Income Tax	-49.92	223.79
	CA SUI/SDI Tax	-17.26	72.33
	Other		
	DENTAL	-5.09*	20.36
	VISION	-2.30*	9.20
	Net Pay	**$1,363.81**	
	Checking 1	-1,363.81	
	Net Check	**$0.00**	

* Excluded from federal taxable wages

Your federal taxable wages this period are $1,725.84

Other Benefits and Information	this period	total to date
Gross Earnings	1,733.23	7,262.61
Gtl	1.62	6.48
Sick Balance	6.97	
Vacation Balanc	75.04	
Total Work Hrs	64.90	

Important Notes
COMPANY PH NO IS : 610-729-5342

CARDIONET LLC
1000 CEDAR HOLLOW ROAD
MALVERN PA 19355

Advice number: 00000080211
Pay date: 02/22/2019

Deposited to the account of	account number	transit ABA	amount
JONATHAN D SHOCKLEY	xxxxxxxx7270	xxxx xxxx	$1,363.81

NON-NEGOTIABLE

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al (800) 736-7401 para oír información grabada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor ("felony").

Employee—complete this section and see note above. *Empleado—complete esta sección y note la nota arriba.*

1. Name. *Nombre.* Jonathan Shockley — Today's Date, *Fecha de Hoy.* 2/19/2019
2. Home Address, *Dirección Residencial.* 1000 Sutter #123
3. City. *Ciudad.* San Francisco — State. *Estado.* California — Zip. *Código Postal.* 94109
4. Date of Injury. *Fecha de la lesión (accidente).* 02/15/2019 — Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar donde ocurrió el accidente.* 33 New Montgomery Street, 4th floor, Suite 450 computer workstation
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Cumulative repetitive stress injury upper extremities, hands, wrists, forearms
7. Social Security Number. *Número de Seguro Social del Empleado.* 217257160
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. Jonathan_shockley@yahoo.com *Correo electrónico del empleado.* _____
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o el administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* [signature]

Employer—complete this section and see note below. *Empleador—complete esta sección y note la notación abajo.*

10. Name of employer. *Nombre del empleador.* BIOTELEMETRY
11. Address. *Dirección.* 1000 CEDAR HOLLOW RD MALVERN PA 19355
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 2-16-19
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 2-19-19
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* 2-21-19
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* CHUBB 202 HALLS MILL RD WHITEHOUSE STATION NJ 08889
16. Insurance Policy Number. *El número de la póliza de Seguro.* 7173-81-54
17. Signature of employer representative. *Firma del representante del empleador.* [signature]
18. Title. *Título.* SENIOR HR COORD — 19. Telephone. *Teléfono.* 847-720-2282

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: Se requiere que Ud. feche esta forma y que provea copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamador y al empleado que hayan presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma del empleado.

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☒ Employee copy/*Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

3/13/19

Rev. 1/1/2014